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REPRINTED FROM THE
New York Medical Journal
for August 6, 1892.

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POSTURE IN PARTURITION.

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From the earliest periods of medical literature, posture in parturition has taken a prominent place, and justly too, as its influences are many and its importance is great. Some of them aid, others retard the function. Some are fœtal, others maternal.

We will only mention a few of the postures which have obtained favor at various times and in various countries.

The *standing* position has been much lauded by several obstetricians in the earlier days of this century; notably among them was Burns, a British obstetrician of great and varied experience. He contended that gravity was in that position used to a greater extent than in any other to facilitate the expulsion of the child, and that the uterine contractions were excited by the constant pressure of the child on the os, which was kept thoroughly moistened by the secretions running freely out; that the constant weight of the child tended to force it out, were it not prevented by the unrelaxed soft parts, more quickly and easily than if muscular effort were required to push it along a horizontal plane. The objections to Burns's argument are twofold—viz., those relating to the child and those to the mother. Those to the child are rupture of the funis, and risk of it

falling on to the floor. Those to the mother, flooding, inversion of uterus, evulsion of placenta, and laceration of perinæum, besides causing unnecessary fatigue. The gravitation theory advanced by him is quite untenable, seeing that the axis of the uterus is in a line with that of the pelvis.

No doubt that during the first stage the uterine action may be increased by the act of walking about, and, if the patient is strong enough, there can be no objections to her doing it for a short time; but as one object ought to be to husband the patient's strength for the final effort, careful watch should be kept, in order that she may not be fatigued.

Another position is that of *kneeling*. This may assume two different postures—viz., kneeling with the arms or elbows resting on a chair or side of the bed, or hands held by a nurse—*i. e.*, with head higher than knees; and secondly, with head or elbows resting on the same plane as the knees. Every obstetrician of experience must have noticed that when a woman is standing on the floor, when seized with a pain, she almost invariably drops on her knees, folding her arms, places them on the most convenient piece of furniture, and lays her head on them, thus remaining till pain is over. For this reason this has been called the "normal posture."

Aveling states that "history certainly proves it to have been widely used in all ages and places." He quotes Chapman's translation of *Homer*, where he places Latona in this position during parturition:

> "When, with her fair hand, she a palm did seize,
> And staying her by it, stuck her tender knees
> Amidst the soft mead, that did smile beneath
> Her sacred labor, and the child did breathe
> The air in th' instant."

This posture, no doubt, is far superior to that of standing. In it the risk of the fœtus being injured by falling is avoided, and the bed prevents the whole of the body from being expelled, as the distance between the bed and the uterus is so short that the full weight of the child can not invert the uterus by dragging on the placenta.

In the second or expulsion stage this posture secures the greatest gravitatory power of the child, as the pelvic outlet is perpendicular.

The other knee position mentioned above is by no means a comfortable one, and certainly does away with the influence of gravitation, therefore is not worth considering further.

The *sitting* posture, once very popular in Europe, is now seldom used. Chairs and stools of great variety have been invented for this purpose. We have on several occasions attended patients who insisted upon this posture, and who claimed for it that it made labor more easy.

Heister well describes one sitting method as follows: "Two common chairs of the same height may be placed together about six or eight inches distant from each other, and tied fast in that position, that the patient may sit with a thigh upon each chair, and the genitals hanging over the intermediate space betwixt them, by which means the os sacrum and coccyx have their free liberty to recede at the time of excluding the fœtus." From our experience of this posture we can not see that it helps the patient, but rather seems to retard the progress of the child by weakening the mother.

Dorsal reclination has been referred to by Aveling in his work on postures as being very commonly adopted still in some countries. He gives a sketch of a sculpture found at Golgas in Cyprus, in a temple erected in honor of Baal and Ashtoreth, the divinities of generative and reproductive power. The date of the original is 300 B. C.

We can appreciate this position in the *first* stage of labor, as it gives the full gravitatory force of the fœtus; but in the second stage it does more harm than good, as the head has to *ascend* through the pelvic outlet: consequently there is no aid from gravitation. Besides this disadvantage, the coccyx will certainly be pressed more or less upward from pressure of the mattress or pillow placed beneath the buttocks. There is also a greater risk of perineal laceration, as the patient, from struggling to eject the fœtus, is apt to slide downward and so tighten the perineal skin and integuments. Aveling states that thirty-nine per cent. of women so delivered have laceration, while in other positions the percentage is fifty-seven.

The side or lateral recumbent position seems to me, of all others, the best. It has been popular in Great Britain for over two hundred years, and perhaps longer. Feilding Ould, and Burton, in their books on obstetrics, published, respectively, in 1748 and 1751, recommend the lateral posture, without, however, specifying right or left. In 1754, Pugh, of Chelmsford, England, in his *Treatise on Midwifery*, was the first to advise the left lateral position. This position has much in its favor for digital examination in all stages and during the whole course of the second and third stages, and, as Pugh says, "it is certainly the most decent," as the operator is behind his patient, which is grateful to the modest primipara, and there is absolutely no necessity for exposure. During the first stage, except when an examination is made, the patient may be allowed any position she has a mind to, the dorsal recumbent being as good as any when she has some point of resistance for the feet and hands. Position takes an important part, however, in the second stage, and, to our mind, the one we are now discussing has most to be said in its favor. The negative reasons why it is the best are the disadvantages already

mentioned in the kneeling and standing postures, and which do not obtain in this position. The positive are that, by raising the shoulders, the gravitatory aid, to a large extent, is given. The risk of perineal laceration is lessened, as there is no stretching of the soft parts. The physician has more freedom of action, as neither the bed nor any part of the patient impedes him. He may sit placidly and comfortably in his chair without breaking his back stooping over his patient, and thus avoiding mental irritation or showing impatience. In instrumental and version cases, by laying the patient transversely across the bed, with the thighs flexed on the abdomen, he can use one or both hands without the necessity of having the limbs held apart by an assistant or the slightest exposure made, as a little practice will enable him to do either beneath the clothes. The risk of perineal laceration with instruments is by this posture reduced to a minimum, as the necessary precaution of supporting the perinæum during the passage of the head is much more easily accomplished. And again, in version, when the head is to be extracted, its weight is taken off the perinæum and placed on the left side of the vagina.

In conclusion, I would ask those who have only used the posture of dorsal reclination to try the left lateral recumbent position, and I am sure that they will find their percentage of perineal lacerations much reduced.

Note.—I maintain that in all primiparous cases the perinæum is lacerated to some extent, and consequently only agree with Aveling's percentage if he includes both multiparous and primiparous cases.